Authorization to Release Health Care Information

Client's Name: _____

Address:_____City_____State____Zip_____

Date of Birth: _____

Regarding the person named above, I REQUEST AND AUTHORIZE (person and/or agency)_____

to release the following information

to Aging Well LLC
Joan McGinnis, MSW, LICSW, GMHS
114 2nd Ave S, Suite 109
Edmonds WA 98020
Phone: 206.571.0491
Joan@JoanMcGinnisMSW.com

In addition, I authorize Joan McGinnis to disclose information regarding care consultation and management services that she provides to me, to _____, in order to facilitate my optimum care.

This request and authorization applies to the following information:

Client Initial _____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

_____ _____ _____
Signature of client or client's authorized representative Date Signed End Date

_____
Relationship if signed by anyone other than client